The use of suitable shoes was advised but was regarded by the lady as impossible from the fact that she was an active platform speaker for the Woman's Suffrage cause, and a disregard of stylish appearance in costume would, she thought, weaken her influence as a speaker. Another similar instance can be mentioned. An energetic lady in charge of a physical culture gymnasium wished advice as to the proper footwear for the gymnastic class of young lady pupils, students for teaching positions in girls' gymnasiums. When advised the use of moccasins, she objected on the ground that her pupils needed stylish slippers and would be unwilling to accept other footwear.

Any one familiar with the various styles of shoes, as well as the disabilities of the feet, is aware that ugly and unsightly shoes, "freak" or queerly constructed boots and shoes, are not necessary to give proper action and play to the muscles and bones of the feet. Shoes of excellent appearance, which do not in any way hamper the feet for any service required by a nurse, can easily be designed and made marketable. For this is needed the coöperative efforts of shoe manufacturers and heads of nurses' training schools and nurses' associations. A comprehensive consideration of the subject would supply the market with proper shoes, and would be of great assistance to those engaged in the nursing profession. If properly placed on the market they would undoubtedly be met by an adequate demand.

In brief, there is a need for a proper nurse's shoe, which should be neat in style, and which must not hamper the action of the nurse's foot.

MATERNITY CENTER WORK[1]

By Ann Stevens, R.N.
Director Maternity Center, New York City

It is not my purpose to go into the details of the history or the organization of the Maternity Center Association, but to give a bird's-eye view of the actual nursing work of the Association.

It may be remembered that at the suggestion of a committee of obstetricians, Manhattan was divided into ten zones, and it was planned to have Maternity Centers in each of these zones, each center to consist of an examining room for patients, a dressing room in order to assure privacy, and a waiting room made as nearly like a comfortable sitting room as possible, where there could be a continuous

[1] Read at a meeting of the New York State Nurses' Association, Brooklyn, October, 1919.

exhibit of a model baby's bed, a layette, a toilet tray, and a properly made mother's bed, prepared for delivery. Around the Center was to be developed an educational campaign to teach all members of the community the need for and value of adequate maternity protection.

This work was to be financed and directed by a voluntary organization of citizens called the Maternity Center Association, formed for the purpose of securing medical and nursing supervision for all pregnant mothers in Manhattan, by coördinating the work of all existing agencies and filling in the gaps, with the view toward reducing maternal deaths and illnesses due to child bearing, and the deaths of infants within the first month of life. The voluntary organization was to continue its work only until a demonstration had been completed, so convincing as to warrant the government's taking over the work with the surety that public moneys would be appropriated for its proper support.

New district development.—When a nurse begins work in a new district, she first learns every facility for maternity care which that district offers. She then visits every organization whose workers might come in contact with pregnant mothers of that district. By every organization, I mean, of course, settlement houses, church clubs, district offices of Relief Organizations, schools, dispensaries or clinics, and all nurses, such as school nurses, baby health station nurses, visiting nurses, etc. To these workers she explains the need for supervision throughout pregnancy, and asks that they refer all pregnant mothers with whom they come in contact, to the maternity center, either by sending the patient directly to the nurse during office hours, or by sending the patient's name and address to the nurse, who will then call on the patient.

Effort to reach every pregnant mother.—With patients referred in this way as a nucleus, the nurse begins work in the district, and while visiting these patients, she canvasses for others. She asks her patients about other pregnant mothers, she asks the janitresses of the tenements; in short, she leaves no stone unturned in her effort to learn of every pregnant mother in her district.

Groups of patients.—On the first visit she makes to these patients, they automatically divide themselves into four groups: 1, Those who have made no arrangement for care at time of delivery; 2, Those who have engaged a private physician; 3, Those who have engaged a private midwife; 4, Those who have registered with a hospital.

Group 1.—The patient who has made no arrangements for care is, of course, the greatest responsibility. The nurse aims to have that patient undergo a complete physical examination by a physician, and she tries to learn all she can of the environment of the patient,

so as to be able to advise her as to the best arrangement for her care at time of delivery. The method the nurse uses to accomplish this aim differs with practically every patient. One of the first fundamentals is gaining the confidence of the patient, then teaching her the need of supervision throughout pregnancy.

She may invite one patient to see the exhibit at the Center or to get help in making the baby clothes, as the best way to get her confidence, while interest in some home problem may reach the next patient, or several friendly visits where doctor or actual nursing are not even mentioned, may be the preliminary work with another, or she may find it possible to begin with a nursing visit and have the patient come to the Center for the next doctor's clinic.

On this first visit the nurse meets with all degrees of receptions, from the patient who says, "I have always had a midwife and never had no trouble, and I don't want a nurse coming to see me," to the patient who considers the nurse's visit a real God-send, and who is anxious to do everything asked. These are extremes, and the latter degree of reception is decidedly less frequent than the former.

Although we consider that, for ideal supervision, an examination by a doctor as early as possible in pregnancy and frequent return visits to the doctor and nurse are necessary,—when the patient fails to coöperate to the extent of having a doctor's examination, we deem the next best thing is to continue to visit that patient at regular intervals so that she may at least have the nurse's supervision.

At the present time the patients are seen once in two weeks up to their seventh month of pregnancy, and once a week after the seventh month. On each of these visits the nurse follows as much of a definite nursing routine as the patient allows. This routine includes analysis of the urine, listening to the foetal heart, asking the patient about, or looking for, all signs and symptoms which are called the danger signals in pregnancy, and giving advice about diet, hygiene, exercise, etc.

During all this nursing supervision, the nurse works with every other organization toward the solution of any problems she finds in that home, for she considers not only the physical condition of the patient, but her peace of mind equally her responsibility.

During this time she also teaches the patient as much as she can about the preparation for her baby, and its care after birth. All this nursing supervision is given by a combination of visits to the patient in her home, and visits which the patient makes to the nurse during her office hours at the Center. The basis for decision as to whether the nurse will visit the patient, or the patient will visit the nurse, is first of all the attitude of the patient, (she never asks a patient to

come to the Center until she feels she has gained her confidence), and then the convenience of the patient (she never asks a patient to come to the Center if she knows that visit would work a real hardship on the patient, either because she is not physically fit, or because she can't leave her children).

If after promising to come to the Center, the patient fails to come, the nurse visits her in her home. Advantages of the patient's coming to the Center are obvious. The patient gets more complete supervision, because blood pressure can be taken at the Center. The nurses do not carry blood pressure apparatus in their bags. Also, one nurse can care for more patients in a given time if the patients do the traveling; the patient sees the exhibit, meets other patients, and gets away from her own environment.

The next responsibility of the nurse in the care of these patients is to advise about the arrangement for care at the time of delivery. The advice is based on the physical condition, as learned by the doctor in his examination, whenever the patient has had one, and the environment in which the woman lives. For instance, if we considered only the physical condition of the patient, we might urge hospital care as the best care from the obstetrician's standpoint, but if we find that by leaving her home, it will become disorganized, we modify our advice to that patient to fit in with her individual home problems. In the same way, if an abnormality arises during pregnancy which, from the clinic obstetrician's point of view, should mean hospital care, and if the home condition would make hospital care unwise, or if the patient should refuse to go to the hospital, the nurse persuades the patient to engage a private doctor, and then either refers her to the Visiting Nurses' Service of the Henry Street Settlement, or makes daily visits herself. Many cases of albuminuria which the clinic doctor felt could only be handled in the hospital have been successfully cared for in this way.

If there is no home problem to be considered, it is usual to advise hospital care for primiparae, and for all patients who develop abnormalities and all patients with a history of former difficult labors or abnormalities.

If the patient wants to be delivered at home by a private doctor, the nurse advises her to engage a doctor as early in pregnancy as possible, and makes sure that the patient understands about the Visiting Nurses' Service of the Henry Street Settlement, telling her of the cost of such service, and going over it with her in detail, in an effort to learn just what proportion of the cost the patient can pay. Then by communicating with the Settlement, the decision is passed on and accepted.

It is in the care of patients to be delivered at home that we meet probably our greatest problem, for it is here that we have to provide for some one to take the mother's place in the home while she stays in bed the necessary time after the baby is born, or while she gets some of the needed rest previous to delivery.

In the one district which is being financed by the Women's City Club, there is available a fund to provide so-called working housekeepers. These working housekeepers are paid about thirty cents an hour, a twenty-five cent lunch allowance, and carfare. This is paid from the fund, and the patient repays what part she can.

For this service the nurses have a list of women, usually the wives of skilled workers, whose own children are partly grown and who are anxious to do part time work in an effort to provide something extra for their children, such as music lessons, a season's gymnasium, phonograph records, etc. These women are, of course, good housekeepers, clean workers, and it is not infrequent that a woman who failed to keep her own house clean, shows marked improvement in the management of her home after she has watched the working housekeeper. We find so many instances of the mother who must do all her housework one or two days after the baby is born, that we feel our care before birth is almost useless unless we can develop some solution to this problem.

If the patient has made up her mind to engage a midwife for delivery, but has not really engaged that midwife, we, of course, do not advise her to do so. We try to steer the patient to either the part pay, or free, outdoor service of a hospital, when one exists, or to that service of the School for Midwives. Here again we meet the same tremendous need for someone to take care of the home while the mother stays in bed. This, to a large extent, is what the midwife does. She comes in to bathe the baby every day, and she does, after a fashion, perform certain household duties.

We find it is not difficult to overcome the desire of the foreign born women to have a midwife, if we can offer a woman physician, or a nurse to accompany the doctor at the time of delivery. This latter is possible in the district where the Henry Street Settlement Nursing Service maintains a twenty-four hour service for attendance at deliveries in the homes. We find the question of household service is usually the point that decides the patient in favor of the midwife.

Even though there are hospital beds to take care of less than 30 per cent. of the women delivered in Manhattan each year, we have as yet found little difficulty in securing hospital care for those patients who most need that care.

Group 2.—If the patient has engaged a private physician, the

nurse gives the patient no treatment or advice, but sends a form letter from the Medical Board to the physician, asking permission to nurse his patient throughout pregnancy, and to report to him on each nursing visit. If he refuses her request to give the nursing care, she dismisses the case. I might say the proportion of physicians who refuse to have the nurse visit their patients is very small. Such patients never come to the doctors' clinic at the Centers, which clinic is maintained solely to give the medical supervision to the patients who would not otherwise get it, but nursing care is given these patients by the same combination of visits to the patient in her home, and patient's visits to the nurse at the Center, as has been outlined.

Group 3.—If the patient has engaged a midwife, the nurse personally visits the midwife. Form letters are impractical, as there are very few midwives who read English. The nurse then asks the midwife to send or bring the patient to the doctors' clinic at the Center, explaining that the midwife is taught to do deliveries, but she is not taught the examination of the heart and lungs, and how to estimate the general condition of the patient, and that now all good obstetricians realize that such an examination is very necessary for the welfare of the mother and the coming baby.

If upon this first examination the doctor finds any abnormality, he does not tell the patient; he either tells the midwife or the nurse explains to the midwife exactly what the doctor has found and points out to her that it is contrary to the regulations governing the practice of midwifery for her to handle that case. She asks the midwife to come to the patient with her, and discuss other arrangements for her care at the time of delivery.

If on this examination the physician finds no abnormality, the midwife is asked to allow the nurse to visit the patient at regular intervals, and to have the patient report to the doctors' clinic in accordance with his advice.

We find midwives are very suspicious of the nurses, and firmly insist that the nurses mean to take their patients away from them. There are a few midwives who speak English and get a clear idea of what the nurses are doing. These give no trouble, but those midwives who do not speak English, and who, even through an interpreter, do not seem to get a clear idea of the work the nurses are trying to do, agree with the nurses during their visits, then promptly tell the patients to have nothing to do with the nurses when they call.

Group 4.—If the patient is registered with a hospital, the nurse's further action depends upon the individual hospital. We have almost as many different working agreements as there are hospitals.

Some hospitals assume the entire nursing and medical supervision of patients as soon as they are registered. Others have not the physical capacity to conduct a sufficient number of clinics to do this, nor do they have visiting nurses to see the patients in their homes, and for that group of hospitals the Maternity Center nurse gives nursing care to the patient, on the same basis that she gives it to a private doctor's patient. The hospital resident assumes the medical supervision of the patient, and receives reports on each nursing visit, and the nurse in turn urges the patient to return to the hospital clinic in accordance with instructions received when she registered.

Some hospitals do not wait for the nurse to discover the patient, but report every day those patients registered at their clinics, and ask that the nurse assume responsibility for the nursing care of those patients.

Each patient whom the nurse has had under actual care up to the time of delivery, and any patient who will let us know when she leaves the hospital, or who is referred by the hospital when dismissed, is visited after delivery for post-natal follow up work. This means a visit to learn whether or not the mother can adapt her instructions in the care of the baby to the conditions in her own home. If not, the nurse teaches her. The importance of attendance at the baby health station, whenever a baby is not under the care of a private physician, is carefully discussed with the mothers and they are all urged to register the baby at the Baby Health Station. The existence of the baby is reported to the Station so that the nurses there may aid in our persuasion to have that baby's supervision continued.

The value of the birth certificate is also explained and discussed with the mother, and the nurse makes every possible effort to have a copy of the birth certificate in the hands of the mother before she dismisses the case. The need for post-partum examination for the mother, not later than six weeks after the birth of the baby, is also explained and urged. Those patients who were delivered in hospitals which provide post-partum examination for their patients, are urged to return to that hospital for that examination, and those patients who would not otherwise have a post-partum examination are urged to come to the Maternity Center doctors' clinics. When the patient has either had this examination or refuses to have it, and the nurse feels she cannot persuade her, the patient is dismissed.

The nurses are just beginning to give some group instructions to the mothers at the Centers. This group instruction is planned as follows: One week the nurse demonstrates to the group the handling of the baby, dressing and undressing, bathing, and explains the reason for making each piece of the layette in just the way it is made, and

the reason for including each article that is included on the toilet tray. She shows them how to make the swabs and boric solution for the mother's and baby's needs, in short, every detail in the daily care of the baby is gone over. The next week the same group of mothers returns, and the mothers demonstrate to the nurse. They actually dress and undress a baby, explain how to make a boric solution, how to prepare sterile water, how to give it to the baby, etc. Many of the mothers return several weeks in succession, and many a mother returns with her three weeks' old baby to make sure she has not forgotten any of the points which the nurse tried to teach her before the baby came.

Most of the mothers who come to these demonstrations are primiparae, and are eager to get all of the information they can from these two demonstrations. To avoid confusion in the minds of the mothers, a uniform method for this teaching has been adopted by all nurses who teach mothers the care of babies.

All agencies doing this district pre-natal nursing have adopted a uniform standard of work, a uniform routine, and are using the same tabulated record form. Each nurse keeps her own record of every patient she sees, takes it into the home with her and passes it on, when she transfers the patient to another organization. A duplicate record is filed in a Central Record Office, kept up to date by the daily reports the nurses send to that office. The nurses of several coöperating agencies also send daily reports of their work to this central record office. Still other organizations do not send the daily reports, but send the finished record after the case is closed; thus providing for study of as great a number of uniform records as possible.

This Central Record Office is also a clearing house for maternity work, and prevents duplication.

THE NURSE AND HER RELATION TO PULMONARY TUBERCULOSIS

BY M. P.

The war has brought with increasing significance to the nurse, as to the whole world, the problem of tuberculosis. What are we going to do about it? How are nurses, to whom the whole country looks as an important factor in this great problem, going to help?

How inadequate is our preparation for efficient service in this particular field. With the exception of those few who have had